

**Prepared Statement of
Professor Thomas L. Greaney**

Before the

**Committee on the Judiciary
United States House of Representatives**

**Subcommittee on Regulatory Reform, Commercial and
Antitrust Law**

on

**“The Patient Protection and Affordable Care Act and the
Consequent Impact on Competition in Healthcare”**

September 19, 2013

Chairman Goodlatte, Subcommittee Chairman Bachus, Committee Ranking Member Conyers, Subcommittee Ranking Member Cohen and Members of the Subcommittee, I much appreciate the opportunity to testify on the important issue of health care consolidation and competition policy in the context of health reform. By way of introduction, I am the Chester A. Myers Professor of Law and Director of the Center for Health Law Studies at Saint Louis University School of Law. I have devoted most of my 26-year academic career to studying issues related to competition and regulation in the health care sector, writing numerous articles on the subject and co-authoring the leading casebook in health law. Before that I served as Assistant Chief in the Antitrust Division of the United States Department of Justice, litigating and supervising cases involving health care. My professional affiliations include membership in the American Health Lawyers Associations and I serve on the Advisory Board of the American Antitrust Institute.

Let me summarize the key points of my analysis of the market concentration problem:

- The Affordable Care Act depends on and promotes competition in provider and payor markets.
- The current extent of hospital market concentration is the result of various “merger waves” over the last twenty years facilitated by erroneous court decisions and lax antitrust enforcement, and exacerbated by government policies.
- There is a broad consensus among economists and health policy experts that concentration in provider markets is a major driver of higher prices in health care and is associated with wide variations in payment and quality around the country.
- It would be erroneous to claim that the Affordable Care Act is somehow responsible for anticompetitive consolidation when in fact such mergers and joint ventures are efforts to *avoid* the procompetitive aspects of the Act.
- The Affordable Care Act encourages procompetitive consolidations through payment reforms and incentives to form efficient delivery systems which have begun to flourish, such as accountable care organizations and patient-centered medical homes.
- The resurgence in antitrust law enforcement should limit future increases in concentration and curb the exercise of market power, but will not unwind most prior consolidations.
- The problem posed by extant provider monopolies lends support for countermeasures including Medicare reimbursement reforms, reducing barriers to entry, and other forms of pro-competition regulation.

Competition Policy and the Affordable Care Act

I'd like to begin with an important proposition that is sometimes lost in the rhetoric about health reform. The Affordable Care Act both *depends on* and *promotes* competition in provider and insurance markets. A key point is that the new law does not regulate prices for commercial health insurance or prices in the hospital, physician, pharmaceutical, or medical device markets. Instead the law relies on (1) competitive bargaining *between* payers and providers and (2) rivalry *within* each sector to drive price and quality to levels that best serve the public.

Why do we need government intervention to make health care markets perform more efficiently? The answer lies in a witches' broth of history, provider dominance, ill-conceived government payment and regulatory policies, and perhaps most importantly, market imperfections that are endemic to delivery of services, insurance, and third party payment. Justification for regulation to promote competition can be found in virtually every economic analysis of health care. Markets for providing and financing care are beset with myriad market imperfections: inadequate information, agency, moral hazard, monopoly and selection in insurance markets that greatly distort markets. Add to that governmental failures—payment systems that reward intensity and volume, but not accountability for resources or outcomes; restrictions on referrals that impede efficient cooperation among providers; and entry impediments in the form of licensure and CON, to name a few. Finally, toss in a strain of professional norms that are highly resistant to marketplace incentives—and you have the root causes of our broken system.

Looking at the result in health care markets, we find the worst of two worlds: *both* fragmentation and concentration. As I'll discuss in a minute, hospital and specialty provider markets are highly concentrated while most primary care physicians have historically operated in "silos" of solo or small practice groups. In most places, there is scant "vertical integration" among providers of different services—a phenomenon that impedes effective bargaining to reduce costs and prevent overutilization of services, and also has adverse effects on the quality of health services patients receive because it inhibits coordination of care.

The Affordable Care Act tackles these problems on many fronts. My article, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*,¹ describes these measures in some detail, but I will focus on a few of the most important. Although it may be counterintuitive to those who dichotomize between competition and regulation, law can *foster* competition by imposing rules and standards, and even by mandating purchasing or creating competition-

¹ Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 Or. L. Rev. 811 (2011).

enabling institutions. As I have argued since the early days of the “competitive revolution” in health care, this kind of regulation is a condition precedent for effective markets.²

To briefly recap some of the ACA’s competition-improving steps:

First, a centerpiece of reform is the Health Insurance Exchange. At bottom, exchanges are really just efficient markets for offering and purchasing health insurance analogous to farmers markets or travel websites. The ACA adopts regulations that are necessary to make insurance products comparable and understandable, that require basic minimums of coverage, and that protect against the insurance industry’s long-standing practice of chasing down only good risks—all textbook efforts to make competition work efficiently in the insurance market.

Second, Medicare payment and delivery reform plays a critical—and generally unappreciated—role in promoting competitive markets, both private and public. Underlying the myriad changes in payment policy and the ACA’s pilot programs and other innovations, such as value-based purchasing, accountable care organizations and reforms to bidding in the Medicare Advantage program, is the understanding that Medicare policy strongly influences the private sector. Private payors often follow Medicare’s lead on payment methods and depend on the program to set quality standards. Moreover, the incentives it creates in the way medicine is delivered has unquestioned spillover effects on commercial health plans. Most notable in this regard are the prodigious efforts undertaken by the ACA to redirect federal payment *away* from fee-for-service payment.

Third, the ACA seeks to create incentives for providers to develop innovative organizational structures that can respond to payment mechanisms that rely on competition to drive cost containment and quality improvement. The watchword here is *integration*. Congress recognized that it was essential to stimulate formation of organizations that could receive and distribute reimbursement and be responsible for the quality of care under the new payment arrangements contained in the ACA and developing in the private sector such as bundled payments and global reimbursements. Given the badly fragmented structure of health delivery, a critical innovation is the Medicare Shared Savings Program, which fosters development of Accountable Care Organizations to serve *both* Medicare beneficiaries and private payers and employers.

Finally, the new law deals with a very significant “public goods” market failure—the underproduction of research and the inadequate dissemination of information concerning the effectiveness and quality of health care services and procedures. The Act does so by subsidizing research and creating new entities to support such research and to disseminate information about outcome and medically-effective treatments. Numerous other provisions attempt to correct flaws in Medicare and Medicaid reimbursement methodologies and add incentives to improve quality by using “evidence based medicine.”

² See Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 Yale. J. on Reg. 179 (1988) (predicting that competition in health care would not succeed if regulation and infrastructure do not support it).

The important take-away is that much of the extensive regulation contained in the new law is explicitly designed to promote competition. It aims to encourage the redesign of payment and delivery systems so that private payers and providers can interact in the marketplace to provide the best mix of cost and quality in health care. As I'll discuss in a moment, however, there are obstacles to realizing the potential benefits of the competitive strategy for health care reform.

Concentration and Antitrust Enforcement

So, what could possibly go wrong? Many observers, including myself, have pointed to the extensive concentration that pervades health care markets and constitute a serious impediment to effective competition. It is important however to put this phenomenon into context—both as to how it came about and what can be done about it.

First, it should be understood that although we have experienced a “merger wave” in recent years, it is not the first, nor is it responsible for the widespread concentration we see in many markets today. Hospital consolidation has proceeded in spurts several times over the past twenty years, with the biggest wave occurring in the mid-1990s. The Robert Wood Johnson Foundation Synthesis Project analysis summarized this phenomenon:

In 1990, the typical person living in a metropolitan statistical area (MSA) faced a concentrated hospital market with an HHI [the index of concentration used in antitrust cases] of 1,576. By 2003, however, the typical MSA resident faced a hospital market with an HHI of 2,323. This change is equivalent to a reduction from six to four competing local hospital systems.³

Notably, the largest number of hospital mergers was undertaken *after* the defeat of the Clinton Health Reform proposal and during a time when managed care was at its zenith. While academics disagree on what caused the sharp increase in mergers, recent studies suggest that hospitals' anticipation of increased cost pressures from managed care led them to consolidate. Moreover, one thing is clear: a series of unsuccessful antitrust challenges to hospital mergers in federal court gave a green light to consolidation. And, as the government antitrust agencies themselves admit, these decisions caused federal and state enforcers to back away from challenging hospital mergers for almost seven years.⁴ Adding to this tale of misfortune is the widely-held opinion that the courts got it wrong: the majority of judicial decisions allowing

³ WILLIAM B. VOGT & ROBERT TOWN, HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? (2006), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1.

⁴ An Assistant Director of the FTC's Bureau of Competition acknowledged, “Both the FTC and the DOJ left the hospital merger business and determined that these cases were unwinnable in federal district court.” Victoria Stagg Elliot, *FTC, in Turnabout, Takes a Closer Look at Hospital Mergers*, American Medical News (April 9, 2012), <http://www.amednews.com/article/20120409/business/304099973/7/>.

hospital mergers found unrealistically large geographic markets that did not conform with sound economic analysis.⁵

The result of this spike in hospital concentration was disastrous for the American public. A large body of literature documents the existence, scope and effects of market concentration. One well-regarded compilation of the numerous studies on this issue spells out the link between hospital market concentration and escalating costs of health insurance: hospital consolidation in the 1990s raised overall inpatient prices by at least 5%, and by 40% or more when merging hospitals were located close to one another.⁶ Another important study, undertaken by the Massachusetts Attorney General, documents the effects of “provider leverage” on health care costs and insurance premiums, notably finding prices for health services are uncorrelated with quality, complexity, proportion of government patients, or academic status but instead are positively correlated with provider market power.⁷ A leading economist summarized the impetus to merge with rivals in the face of pressure from payers to compete:

I have asked many providers why they wanted to merge. Although publicly they all invoked the synergies mantra, virtually everyone stated privately that the main reason for merging was to avoid competition and/or obtain market power.⁸

Provider concentration has a double effect—one in commercial markets, the second on government payers, especially Medicare. The most obvious effect, as described above, is to increase dominant providers’ ability to command higher prices and resist efforts to limit unnecessary procedures. A second effect, often overlooked, is the cost-elevating impact of provider market concentration upon government payers. Examining the effect of hospital concentration on Medicare payments, the Medicare Payment Advisory Commission (MedPAC) has found that high hospital margins on private-payer patients tend to induce more construction and higher hospital costs and that, “when non-Medicare margins are high, hospitals face less pressure to constrain costs, [and] costs rise.”⁹ These factors, MedPAC observes, explain the counterintuitive phenomenon that hospital Medicare margins tend to be low in markets in which concentration is highest, while margins are higher in more competitively structured markets.

⁵ See e.g., Cory S. Capps et al., *The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers* (Nat’l Bureau of Econ. Research, Working Paper No. 8216, 2001), available at <http://www.nber.org/papers/w8216>.

⁶ VOGT & TOWN, *supra* note 3.

⁷ MASSACHUSETTS ATTORNEY GENERAL, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 6½(B) (2010), available at: <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf>. Compare with the 2011 and 2013 updates, available at <http://www.mass.gov/ago/docs/healthcare/2011-hcctd.pdf> and <http://www.mass.gov/anf/docs/hpc/ag-presentation.pdf>, respectively.

⁸ DAVID DRANOVE, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE: FROM MARCUS WELBY TO MANAGED CARE 122 (2000).

⁹ MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: IMPROVING INCENTIVES IN THE MEDICARE PROGRAM xiv (2009), available at http://www.medpac.gov/documents/mar09_entirereport.pdf.

The key point to be derived from the past twenty years of experience with hospital consolidation is that, if not checked by vigilant antitrust enforcement, it can undermine the benefits that competition offers. Further, mergers that concentrate local markets have largely been driven by a desire to gain bargaining leverage. (It is important to note of course that not all consolidation is harmful: many hospital mergers do not affect local markets as they substitute a stronger, more efficient owner not currently competing in the market or they involve relatively small competitors in the same market.) In sum, it would be highly misleading to suggest that the Affordable Care Act is somehow responsible for a new wave of attempted anticompetitive provider mergers, when in fact those mergers are an effort to *avoid* the very pro-competitive policies the new puts in place.

Turning to the payer side, health insurance markets have a long history of consolidation and increasing concentration in the individual and small group market, where, according to some data, two firms have greater than fifty percent of the market in twenty-two states, and one firm has more than fifty percent in seventeen states.¹⁰ The results in these markets appear to confirm what economic theory predicts: higher premiums for consumers and high profits for the insurance industry. Summarizing studies indicating that private insurance revenue increased even faster than medical costs; economists at the Urban Institute concluded that “the market power of insurers meant that they were not only able to pass on health care costs to purchasers but to increase profitability at the same time.”¹¹ While some studies question the extent of insurers’ exercise of market power, bilateral market power is unlikely to serve consumer interests. Finally, experience suggests that entry into concentrated insurance markets is far from easy and may be unlikely to occur in markets with few insurers. A recent study by the Antitrust Division of the Department of Justice found that entry in such insurance markets was impeded by the difficulty of securing provider contracts.¹² Congress addressed the problem in several ways: encouraging formation of new competition via nonprofit insurance cooperatives and multi-state health plans. Although the proposal to include a public option plan in every market was rejected, by improving insurance markets, reducing risks of adverse selection, and establishing health insurance exchanges, the ACA took steps designed to induce de novo entry into concentrated insurance markets.

¹⁰ KAREN DAVENPORT & SONIA SEKHAR, CTR. FOR AM. PROGRESS, *Insurance Market Concentration Creates Fewer Choices: A Look at Health Care Competition in the States* (Nov. 5, 2009), available at http://www.americanprogress.org/wp-content/uploads/issues/2009/11/pdf/health_competition_1109.pdf.

¹¹ JOHN HOLAHAN & LINDA BLUMBERG, URBAN INST., HEALTH POLICY CTR., CAN A PUBLIC INSURANCE PLAN INCREASE COMPETITION AND LOWER THE COSTS OF HEALTH CARE REFORM? 3 (2008), available at http://www.urban.org/UploadedPDF/411762_public_insurance.pdf.

¹² The Department of Justice’s study concluded:

[T]he biggest obstacle to an insurer’s entry or expansion in the small- or mid-sized-employer market is scale. New insurers cannot compete with incumbents for enrollees without provider discounts, but they cannot negotiate for discounts without a large number of enrollees. This circularity problem makes entry risky and difficult, helping to secure the position of existing incumbents.

Christine A. Varney, Assistant Att’y Gen., Antitrust Div., U.S. Dep’t of Justice, *Remarks as Prepared for the American Bar Association/American Health Lawyers Association Antitrust and Healthcare Conference*, May 24, 2010, available at <http://www.justice.gov/atr/public/speeches/258898.pdf>.

The Resurgence of Antitrust Enforcement

In recent years the Federal Trade Commission, the Antitrust Division, and a number of State Attorneys General have stepped up antitrust enforcement. The federal antitrust agencies' cases, along with competition advocacy in the legislative and regulatory arenas, have focused on (1) stopping anticompetitive mergers, (2) challenging the exercise of market power by dominant providers and insurers, (3) urging legislators to reject or remove barriers to competition or legislative exemptions from the antitrust laws, and (4) attacking competitor collusion, most notably between manufacturers of branded pharmaceuticals and generic entrants and provider collusion in managed care negotiations. In addition, state attorneys general and private litigants have brought a number of important antitrust cases principally in the merger area.¹³

These cases and legislative comments constitute a significant and necessary step toward protecting the competitive policies that undergird the Affordable Care Act. In the merger area, for example, the FTC has challenged four highly concentrative hospital mergers in the last three years.¹⁴ Further, in an important case decided last year, the Supreme Court overturned the lower court's interpretation of the state action doctrine which it found erroneously shielded a hospital merger to monopoly.¹⁵ Notably, the FTC and state attorneys general have also investigated and challenged mergers of physician practices and acquisitions of physician practices by hospitals.¹⁶ The Department of Justice challenged, and settled by consent decree requiring divestitures, a merger of health insurers that would reduce competition in Medicare Advantage contracting¹⁷ and forced another health plan to abandon its plan to acquire its

¹³ Because my testimony today focuses on provider and payor competition, I am omitting what is undoubtedly the most significant antitrust enforcement effort in health care: the challenge to pay-for-delay agreements in the pharmaceutical sector. The Supreme Court's decision in *FTC v. Actavis, Inc. et al.*, cleared the way for future challenges to the agreements that divide markets for pharmaceutical products, an activity that is estimated to involve costs of \$3.5 billion per year. 570 U.S. ____ (2013).

¹⁴ *In the Matter of* OSF Healthcare System, and Rockford Health System, No. 111-0102, F.T.C. Docket No. 9349, (F.T.C. April 13, 2012) (dismissed upon merger abandonment), *available at* <http://www.ftc.gov/os/adjpro/d9349/120413rockfordorder.pdf>; *In the Matter of* ProMedica Health System, Inc., No. 111-0167, F.T.C. Docket No. 9346 (F.T.C. March 28, 2012) (petition for review on file with 6th Circuit, No. 12-3104), *available at* <http://www.ftc.gov/os/adjpro/d9346/120328promedicabrillopinion.pdf>; *In the Matter of* Reading Health System and Surgical Institute of Reading, No. 121-0155, F.T.C. Docket No. 9353 (F.T.C. Dec. 7, 2012) (dismissed upon acquisition abandonment), *available at* <http://www.ftc.gov/os/adjpro/d9353/121116readingsurgicalcmpt.pdf>; *FTC v. Phoebe Putney Health System, Inc.*, 568 U.S. ____ (2013).

¹⁵ *Id.* (holding that because Georgia has not clearly articulated and affirmatively expressed a policy allowing hospital authorities to make acquisitions that substantially reduce competition, state-action immunity does not apply).

¹⁶ See Complaint for Permanent Injunction, FTC and State of Idaho, Plaintiffs, v. St. Luke's Health System, Ltd, and Saltzer Medical Group, P.A., No. 1:12-cv-00560-BLW-REB (D. Idaho March 12, 2013); Press Release, FTC Bureau of Competition Director Richard Feinstein, Feinstein Statement on Providence Health & Services' Abandonment of its Plan to Acquire Spokane Cardiology and Heart Clinics Northwest (April 8, 2011), <http://www.ftc.gov/opa/2011/04/providence.shtm>. See also *In the Matter of* Renown Health, No. 111-0101, F.T.C. Docket No. C-4366 (F.T.C. Dec. 4, 2012) (settled by consent agreement), *available at* <http://www.ftc.gov/os/caselist/1110101/121204renownhealthdo.pdf>.

¹⁷ Order, *United States v. Humana Inc. and Arcadian Management Services, Inc.*, No. 1:12-cv-00464-RBW (D.D.C. March 28, 2012), *available at* <http://www.justice.gov/atr/cases/f291400/291486.pdf>.

leading rival.¹⁸ Together these cases should send a strong signal that consolidations will be closely scrutinized.

A second series of cases involve challenges to the actions of dominant providers or dominant payers. These cases represent a marked departure from the posture of the agencies over the last two decades in which the government agencies have rarely taken on cases of monopolization or abuse of dominant position. The conduct at issue involves a variety of “exclusionary” actions: vertical arrangements that foreclose rivals without significant efficiency justifications. For example, the Antitrust Division challenged a dominant insurer’s insistence on “most favored nations” clauses from contracting hospitals that severely disadvantaged rival insurers.¹⁹ This case was dismissed after the Michigan legislature essentially agreed that MFNs were harmful to competition and prohibited their use in health care contracts.²⁰ In another case, settled by consent decree, the Division challenged a near-monopoly hospital’s demands for exclusionary discounts from insurers.²¹

Preserving the Potentially Pro-competitive Effects of Accountable Care Organizations

Of the many important innovations contained in the Affordable Care Act, the Medicare Shared Savings Program (MSSP), which promotes the development of accountable care organizations, has undoubtedly garnered the most attention. The ACO strategy takes direct aim at the twin problems of the health care system: fragmented delivery and payments that reward volume rather than performance. Because they will be accountable for the full range of care needed by beneficiaries, ACOs need to establish integrated networks of providers that can monitor quality and provide seamless, cost-effective care. The Affordable Care Act explicitly encourages Medicare ACOs to also serve the commercially-insured sector and self-funded employers.

From the standpoint of competition policy, ACOs offer an important opportunity for providers to align in entities capable of delivering care that consumers (employers, insurers and individuals) can compare and negotiate with to get the best bargain in price and quality. Thus *both* provider integration and rivalry are key to the success of the concept. CMS, the FTC and the Department of Justice have worked closely together to establish guidelines²² that will help

¹⁸ Press Release, U.S. Dep’t of Justice, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans (Mar. 8, 2010), http://www.justice.gov/atr/public/press_releases/2010/256259.pdf.

¹⁹ Complaint, United States v. Blue Cross Blue Shield of Michigan, No. 2:10-14155-DPH-MKM (E.D. Mich. Oct. 18, 2010), *available at* <http://www.justice.gov/atr/cases/f263200/263235.pdf>. *See also* Press Release, U.S. Dep’t of Justice, Justice Department Files Antitrust Lawsuit Against Blue Cross Blue Shield of Michigan (Oct. 18, 2010), http://www.justice.gov/atr/public/press_releases/2010/256259.pdf.

²⁰ Press Release, *supra* note 18. *See also* Stipulated Motion and Brief to Dismiss without Prejudice, United States v. Blue Cross Blue Shield of Michigan, No. 2:10-14155-DPH-MKM (E.D. Mich. March 25, 2013), *available at* <http://www.justice.gov/atr/cases/f295100/295119.pdf>.

²¹ Final Judgment, United States v. United Regional Health Care System, No. 7:11-cv-00030-O (N.D. Tex. Sep. 29, 2012), *available at* <http://www.justice.gov/atr/cases/unitedregional.html>.

²² Final Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (October 28, 2011).

providers assess the antitrust boundaries when forming ACOs. By some estimates there are over 488 ACOs operating in all 50 states, over 250 of which are participating in the Medicare Shared Savings and Pioneer programs.²³

Several procompetitive aspects of the agencies' regulations and policy statements should be noted. First, the MSSP allows ACOs considerable flexibility in the way they organize themselves. ACOs may be formed by joint ventures among providers and exclusive contracting is permitted only to the extent it does not impair competition. Exceptions are established for rural providers that recognize the special competitive circumstances they face. Dominant providers are constrained to some extent and cautioned about specific practices that interfere with payers' ability to engage in competitive contracting. Finally, CMS will gather data and monitor carefully the performance of participating ACOs.

There are, to be sure, legitimate concerns that ACOs may form in a manner that allows providers to aggregate market power that can be exercised over private health plans and employers. At the same time, ACOs offer a distinct opportunity to increase the competitiveness (and hence the quality and cost-effectiveness) of the delivery system. The antitrust agencies and CMS appear to have set out a framework capable of monitoring the competitive implications of ACOs as they develop.

Addressing the Provider Concentration Problem

While the antitrust agencies' efforts to promote and protect competition in health care markets is commendable, it is also the case that antitrust law has little to say about monopolies lawfully acquired, or in the case of consummated mergers, entities that are impractical to successfully unwind. Given the high level of concentration in many hospital markets and a growing number of physician specialty markets, it is particularly important to encourage other measures that promote competition. Pro-active, pro-competition governmental interventions may be needed.

Although there is no single "silver bullet" to solve the problem posed by extant provider concentration, there are a number of steps that reduce the market power exercised in such markets.²⁴ To begin with, laws that impose barriers to entry should be amended or repealed. For example, hospital concentration may be lowered in some states by eliminating government-imposed barriers to entry such as Certificate of Need laws. Likewise, although some restrictions on physician-controlled hospitals are desirable to prevent their "cherry picking" patients, current law unnecessarily impedes their development. In addition, allowing middle-level professionals, such as nurse practitioners and physician assistants to practice within the

²³ LEAVITT PARTNERS, GROWTH AND DISPERSION OF ACCOUNTABLE CARE ORGANIZATIONS: AUGUST 2013 UPDATE (2013), *available at* <http://leavittpartners.com/wp-content/uploads/2013/08/Growth-and-Dispersion-of-ACOs-August-20131.pdf>.

²⁴ Several organizations have begun looking at ways to address the provider monopoly problem. *See e.g.*, CATALYST FOR PAYMENT REFORM, PROVIDER MARKET POWER IN THE U.S. HEALTH CARE INDUSTRY: ASSESSING ITS IMPACT AND LOOKING AHEAD (2012), *available at* http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf.

full scope of their professional license under state law may increase the number and viability of new organizational arrangements such as medical homes and accountable care organizations that may be able to exert pressure on dominant providers.²⁵ Because Medicare payment policies strongly influence the methodologies adopted by private payors, encouraging and accelerating the myriad efforts at reimbursement reform currently underway would help insure that dominant providers adopt quality-improving, cost-effective practices. Finally, as a general matter federal and state legislatures should stoutly resist pleas for immunity or special protections from competition laws; there is a strong consensus, based on the nation's experience, that such exemptions harm consumer welfare.²⁶

A second means of dealing with provider concentration is to use the full measure of authority under the antitrust laws to challenge the *abuse* of market power by dominant hospitals, physician groups and pharmaceutical companies. Among the important issues on the antitrust agenda are resisting claims of "State Action" where the state legislation does not follow the Supreme Court's requirement that the defense is available only where state law truly endorses anticompetitive conduct and the state actively supervises the effects on consumers. Other steps might include retrospective challenges to recent mergers where divestiture is feasible. Further, following some path-breaking scholarship by Professors Havighurst and Richman, antitrust law may be deployed to charge dominant hospitals with illegal tying or bundling, so as to force them to compete on the services that they do not monopolize.²⁷

Finally, it may be possible to strengthen private market participants' ability to negotiate with dominant providers through governmental actions. For example, commercial insurers are currently engaged in testing a variety of devices, such as using tiered networks, reference pricing, and value pricing to incentivize patients to choose more cost-effective providers, equipment, and service options. However, dominant providers have insisted on contractual terms (e.g., so-called "anti-tiering" clauses) to block such arrangements. Although antitrust law might in some instances prohibit such agreements, more direct, regulatory prohibitions would provide much-needed protections more efficiently. And as discussed earlier, states might follow Michigan's example in outlawing most favored nations agreements that have been shown to reduce price competition in both the hospital and insurance sectors. The expertise and leverage of agencies regulating insurers might also be called upon. For example, state

²⁵ The FTC staff has addressed the issue of expanding the opportunity of complementary providers to compete in several letters to state legislatures. See e.g., Letter from FTC Staff, to the Hon. Theresa W. Conroy, Conn. State Rep. (March 19, 2013) (on file with author) (supporting proposed legislation to remove certain restrictions on advanced practice registered nurses' ability to practice within their scope of practice), *available at* <http://www.ftc.gov/os/2013/03/130319aprnconroy.pdf>.

²⁶ As the nonpartisan Antitrust Modernization Commission has explained, antitrust exemptions "should be recognized as a decision to sacrifice competition and consumer welfare" that benefits small, concentrated interest groups while imposing costs broadly upon consumers at large. ANTITRUST MODERNIZATION COMM'N, REPORT AND RECOMMENDATIONS 350 (2007), *available at* http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

²⁷ Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 Or. L. Rev. 847 (2011).

health insurance exchanges or state regulators might require unbundling of hospital services, as suggested by Professors Havighurst and Richman. For its part, CMS should carefully review the performance of ACOs, and where appropriate, decline renewal of contracts if market power has been exercised over private payers. Likewise, regulations and payment policies that favor ACOs controlled by primary care providers rather than dominant hospitals could serve to reduce the impact of the latter's market power.

It should be remembered that the foregoing options are designed to address the provider monopoly problem while preserving the market paradigm on which health care reform currently rests. A last resort, should other options fail, would be to invoke regulatory authority to curb excessive pricing, such as requiring all payer rate controls or empowering insurance commissioners to place caps on excessively expensive provider contracts.

Conclusion

A core concern of the Affordable Care Act is promoting competition in health care. Responses to the law such as anticompetitive mergers and cartel activity should be understood as efforts to avoid the discipline the new market realities will impose. Vigorous enforcement of the antitrust laws is essential to dealing with those problems, but at the same time the law is of limited help in dealing with extant market power. Legislators and regulators should be alert to opportunities to improve the prospects for entry and increased competitive opportunities where monopoly power is present.